

STATE OF CONNECTICUT
State Innovation Model
Quality Council

Meeting Summary
Wednesday, September 3, 2014

Members Present: Gregory Barbiero; Rohit Bhalla; Aileen Broderick; Mehul Dalal; Deb Dauser Forrest; Karin Haberlin; Gigi Hunt; Elizabeth Krause; Steve Levine; Arlene Murphy; Robert Nardino; Meryl Price; Jean Rexford; Andrew Selinger; Todd Varricchio; Steve Wolfson; Thomas Woodruff

Members Absent: Mark DeFrancesco; Daniela Giordano; Kathleen Harding; Kathy Lavorgna; Donna O'Shea; Rebecca Santiago

Other Participants: Mark Schaefer

Meeting was called to order at 6:06 p.m.

1. Introductions

Mehul Dalal chaired the meeting. Participants introduced themselves.

2. Public Comment

There was no public comment.

3. House rules/executive team

Dr. Dalal provided background on the State Innovation Model and the workgroups. The Council reviewed house rules. Members were asked to volunteer to serve on the Council's executive team. The executive team will comprise Dr. Dalal (state agency representative), Deb Dauser Forrest (payer representative), Meryl Price (consumer/advocate representative), and Steve Wolfson (provider representative).

4. CT State Innovation Model Test Application

Mark Schaefer, Director of Healthcare Innovation, provided an overview of the SIM Test Grant Application ([see presentation here](#)). Dr. Wolfson said that attribution was a problem in primary care as specialists and hospitals often dictate much or all of the cost of a patient's care. That leaves primary care physicians with very little control. Andrew Selinger highlighted his experience at ProHealth, which is in its second year as an accountable care organization. They have compacts with specialists for preferential referrals but those compacts do not include shared savings. He said he was not sure how shared savings would be arranged in a more diverse primary care network.

Jean Rexford asked about cost transparency to consumers. Dr. Schaefer said it could be within the Council's purview to determine a means to increase cost transparency. Thomas Woodruff said that each health insurer posts the costs for procedures on its web site for its members but that individual doctors tend not to know those costs. He said transparency needs exist.

Arlene Murphy asked Dr. Schaefer to talk about how Medicaid is represented on the Council. Dr. Schaefer said that Greg Barbiero is represented Community Health Network of Connecticut (CHNCT) on the Council. CHNCT serves as the administrative service organization for the state's Medicaid program. Additionally, Ms. Price and Daniela Giordano have Medicaid expertise. The

Council on Medical Assistance Program Oversight, which oversees the state's Medicaid program, will designate one or two additional members. Those additional members will likely be legislators. None of the decisions the Council makes will be binding. All of the payers involved (including Medicaid) will need to decide whether to take up the Council's recommendations.

5. Quality Council Charter and Roadmap

The Council reviewed the charter ([found here](#)). Dr. Schaefer asked members to identify stakeholder groups that should be brought to the table to provide advice. Dr. Wolfson said that dental care is not represented but is crucial. He said that the areas that bear on employability are orthopedics, ophthalmology, and dental care and while the CT State Medical Society represents the first two, they do not represent the last. He said there is a lack of access to dental care. Dr. Schaefer said that CMMI is looking for work in the area of oral health but coverage is a big barrier. While pediatric oral health is included in the health exchange plans, adult coverage is not. There is a dearth of both oral health measures and health equity measures. Further, there is a lack of data with regard to gender, race and ethnicity. Rohit Bhalla said they should think beyond ambulatory care and at other types of providers such as home health. Ms. Price asked whether there were decisions that have already been made. Dr. Schaefer said there is very little that has been decided upon other than the charter, and even that is a draft.

Ms. Murphy asked for clarification between the work of the Quality Council and the work of the Equity and Access Council. She was concerned about duplication of efforts. Dr. Schaefer said that the Quality Council will be considering timely access to necessary services and other access issues. The Equity and Access Council will be looking at under service beyond measures, including the development of methods of under service detection. Elizabeth Krause suggested the clarification be added to the charter.

The Council discussed the target population. They will be looking at the entire state's population – those covered by Medicare, Medicaid, and commercial plans. Each payer could place value on different issues and there is the risk of developing a very narrow set of measures to each particular group. They group discussed find more universally appropriate measures. Dr. Wolfson said they also would need to be mindful of health information technology limitations. The goal is to develop a cross payer report card. The program management office is talking with the Department of Social Services and the All Payer Claims Database about how that can be accomplished. Todd Varricchio said that the thought process at Aetna is that a common report card is the right thing to do; however, they are looking at the potential for multiple state scorecards. He stressed the need for flexibility.

6. Guiding Principles

Dr. Schaefer provided a review of CMMI's questions on the state's test grant application. It has been made clear that CMMI would prefer the state maximize alignment with Medicare shared savings programs/accountable care organization measures. The group engaged in a brainstorming session to identify a preliminary set of principles. Those included: aligning with the Medicare ACO so that there is less burden; measure integrity; continually improving the Triple Aim; and developing a comprehensive measurement set.

The Council discussed aligning with the Medicare ACO measures. Dr. Bhalla said the measures should represent the population as a whole, particularly if they are looking at population health. He said, as an example, Medicare does not look at asthma but that it is a huge issue for the Medicaid population. Council members agreed that they would align with Medicare wherever possible but that they should aim to develop a measure set that encompassed the population as a whole. Dr.

Schaefer said that maximizing alignment does not mean they would adopt all of Medicare's measures. He also suggested that Council members be mindful of creating an added burden on providers.

7. Next Steps

The Council discussed and decided to meet on September 23. The plan is to present measurement sets currently in use and to capture categories. The group will finish the discussion on guiding principles as they were not fully captured in the meeting. Dr. Schaefer asked Council members to share what they think should be included as guiding principles.

Meeting adjourned at 8:04 p.m.